Correspondence

Cost-Effectiveness of Coronary Care

To THE EDITOR: It was with a profound sense of déjà vu that I read Murata's article[1] and Goldman's editorial[2] in the May issue recommending that, as a cost-saving measure, patients with chest pain who are at low risk for myocardial infarction (MI) be treated in an intermediate rather than an intensive coronary care unit (CCU). That discussions of this type continue to take place 25 years after coronary care units were first introduced seems little short of extraordinary and demands additional explanation.

It was always clear that clinical risk in the context of potential and actual myocardial infarction varies widely. This concept was incorporated into the design and operation of one of the earliest CCUs in California. At the Peninsula Hospital in Burlingame, patient triage has been used since 1965 to match intensity of care to anticipated risk. Remote monitoring was provided to low-risk patients in a minimally altered hospital wing, while more critical patients were treated under direct vision in an intensive care unit-type environment.

The efficient use of resources was designed to permit longer periods of monitoring than the 48 hours that were considered standard at the time. In a deliberate attempt at economy, 11 remotely monitored beds were installed at a cost of $29,900. Adding only 50 cents per hour to the normal daily hospital room rate covered both installation and operating expenses and amortized the cost of equipment. Even in 1964, this was a bargain.

In keeping with the experience at other institutions, in-hospital myocardial infarction mortality rates at the Peninsula Hospital fell from 26% to 15%. These results were achieved even though the vast bulk of care from admission to discharge was provided in the less intensive unit.[3] Still, this approach was eventually abandoned in favor of more expensive full-bore treatment for all suspected MI patients. Why? For a variety of extraneous reasons, which have militated against greater economic efficiency in coronary care at Peninsula Hospital and, I suspect, at virtually all institutions.

Most important, the enactment of Title 22 of the California health code eliminated local option in CCU design. Private rooms of a specific size and with specific equipment were mandated by law in an effort to improve and codify standards. Anything less no longer qualified as a bona fide CCU. This had intensely practical consequences, since Medicare and other insurers stopped paying any surcharge above basic day rates for care rendered in non-qualifying facilities.

Nor in the example given above did the surcharge long remain at 50 cents per hour. Hospital rates are set by accountants who compare local charges with those of other institutions. Higher charges elsewhere offer an opportunity to raise rates with little fear of criticism. Physicians are not generally welcome if they object to the conversion of an inexpensive CCU into a profit center.

For those physicians interested in cost-effective coronary care, no constituency for keeping things simple was to be found. The focus at clinical meetings lay elsewhere. Cardiology itself evolved into a more complex and invasive specialty, and the continuous upgrading of facilities and services seemed to have a momentum of its own. Rivalry with other institutions and local prestige factors may also have played a role, affecting nurses as well as physicians. Subspecialty care, with its inherent bias toward complexity, has made progressive inroads into the cardiologic portion of the practices of general internists and other primary physicians, even with low-risk patients.

In short, it has always been reasonable to treat low-risk suspected myocardial infarction patients in an intermediate rather than an intensive CCU. But there remain important socioeconomic, regulatory, and professional obstacles to doing so.

PHILIP R. ALPER, MD
1838 El Camino Real, Suite 102
Burlingame, CA 94010

REFERENCES

1. Murata GH: 'Ruling out' myocardial infarction in the coronary care unit—University of New Mexico (Specialty Conference). West J Med 1988; 148:555-560
2. Goldman L: Ruling out myocardial infarction—Updating a good idea (Editorial). West J Med 1988; 148:573-574
3. Alper PR: Cost versus effectiveness in coronary care (Letter). Am J Cardiol 1974; 34:748

Experience of a 'Dirtball' Patient at a University Hospital

To THE EDITOR: It has been over half a decade since Cato 6 eloquently reminded us of the inappropriateness of the term "dirtball" when applied to a patient.[1] While most caregivers refrain from using such nouns, their expressions and actions may make the patient feel like a "dirtball." I was recently unfortunate enough to require emergency treatment at a local university hospital. There was a profound and unpleasant difference between the treatment I got from those who knew me as a medical student and those who only saw me as I presented.

While bodysurfing, I received a flexion injury to the neck, resulting in severe pain that radiated down my right arm. I was told to lie still in the sand as the paramedics tied me to the spineboard and prepared to transfer me to hospital. Now, imagine if you will what I must have looked like coming into the emergency room on a Friday night: a man with a five o'clock shadow, dressed only in tattered shorts, wet, hair and body matted with dirt and sand, and tied to a spineboard. While the intern—who happened to be a good friend—proceeded with a thorough neurologic examination, the nurse exclaimed in an extremely annoyed voice (as if I couldn't hear), "Oh my god . . . this guy's getting dirt all over the place." Next, the same professor who had given me superior marks on my surgery oral exams the month before did not recognize me and gave me a look and a shake of the head that seemed to say, "Oh no . . . another dirtball." In each section of the hospital, those who knew me rolled out the red carpet and those who didn't had "dirtball" in both their expressions and actions. While sitting in the emergency room with some of the other "dirtballs," I couldn't help but think how miserable it must be to be treated like this all the time.

Luckily, I emerged from the incident with no permanent injury. Now, when I care for unpleasant or even hateful patients, I make an extra effort in both my words and actions to

let them know that I care and will work my hardest to help them. We must remember that no matter how dirty, smelly, unpleasant, or hateful patients are, they have come to us because they are in need. And that dirtball might just be the medical student who rotates through the emergency room next month.

STEVE RIMMER
Fourth Year Medical Student
University of California, San Diego, School of Medicine
2157 Caminito Del Barco
Del Mar, CA 92014

REFERENCE

1. Cato 6: Dirtball. JAMA 1982; 247:3059-3060

Deficiencies in Soviet Medicine

To THE EDITOR: Having read the letter from Drs Rafferty and Schultz[1] commenting on Friedenberg's article on the Soviet health care system,[2] I was encouraged to re-read that article. I had the pleasure and honor of following Drs Rafferty and Schultz as an exhibit physician into Tbilisi, Soviet Georgia, for two months; they had served at Kiev and Rostov.

I, too, feel that Dr Friedenberg is unnecessarily kind in his assessment of Soviet medical care and, in some instances, in error.

The examples of deficiencies in Soviet medicine are too numerous to mention in a letter, and in this sense they reflect exactly what is going on in the rest of Soviet society. It may be simpler just to say that in no respect does their system, in its philosophy or execution, serve as a model for anyone else's. Nor, at this time, are its foundations or accomplishments sufficient to be the basis for improvement. Just as the rest of their society has stagnated, so has their health care system.

It may very well be, as Drs Rafferty and Schultz point out, that Soviet health expenditures are 2% of their gross national product. The real cost in mortality and morbidity and the unmeasured cost and effort of trying to circumvent the system to obtain decent care could easily push that figure into double digits, however.

We must help our Soviet colleagues in every way we can. This cannot be accomplished until the *glasnost,* which is the essence of scientific intercourse, is allowed to permeate this until now impenetrable border, mind and soul. This effort is not at all abetted by abrogating our usual high standards of criticism, which began with the Flexner report. Would that it were applied to Soviet medicine.

Dr Friedenberg is doing a disservice to our Soviet brethren by permitting them to compare their present standards to their past accomplishments and not to present-day western ones. Even by their own standards, they have regressed. Free care is the hubris on which the Soviets base their criticism of our system. For Dr Friedenberg to grab their banner, knowing full well the real cost of free care, is to gloss over the failure of the system, which has done very little in 70 years except to remain nominally free.

MYRON GANANIAN, MD
Palo Alto Medical Foundation
Health Care Division
300 Homer Ave
Palo Alto, CA 94301

REFERENCES

1. Rafferty M, Schultz D: Medicine in the USSR (Correspondence). West J Med 1988; 148:585
2. Friedenberg DS: Soviet health care system. West J Med 1987; 147:214-217